

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0005090</u></p> <p><b>Facility Name:</b> <u>Lutheran Home For The Aged</u></p> <p><b>Address:</b> <u>800 West Oakton</u> <u>Arlington Hts</u> <u>60004</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(847) 253-3710</u> <b>Fax #</b> <u>(847) 253-1427</u></p> <p><b>IDPA ID Number:</b> <u>362192824002</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>08/01/60</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/02</u> to <u>06/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 829"> <b>Officer or Administrator of Provider</b> </td> <td data-bbox="1283 678 1923 748">         (Signed) _____          (Date) _____       </td> </tr> <tr> <td data-bbox="1150 748 1283 829"></td> <td data-bbox="1283 748 1923 802">         (Type or Print Name) <u>Kenneth W. Huff</u> </td> </tr> <tr> <td data-bbox="1150 802 1283 829"></td> <td data-bbox="1283 802 1923 829">         (Title) <u>Vice President of Finance</u> </td> </tr> <tr> <td data-bbox="1150 829 1283 1040"> <b>Paid Preparer</b> </td> <td data-bbox="1283 829 1923 883">         (Signed) <u>See Accountants' Compilation Report Attached</u>          (Date) _____       </td> </tr> <tr> <td data-bbox="1150 883 1283 1040"></td> <td data-bbox="1283 883 1923 937">         (Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u> </td> </tr> <tr> <td data-bbox="1150 937 1283 1040"></td> <td data-bbox="1283 937 1923 1008">         (Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u>  <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> </td> </tr> <tr> <td data-bbox="1150 1008 1283 1040"></td> <td data-bbox="1283 1008 1923 1040">         (Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u> </td> </tr> </table> <p><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Date) _____		(Type or Print Name) <u>Kenneth W. Huff</u>		(Title) <u>Vice President of Finance</u>	<b>Paid Preparer</b>	(Signed) <u>See Accountants' Compilation Report Attached</u> (Date) _____		(Print Name and Title) <u>Steven N. Lavenda, C.P.A.</u>		(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>
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## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Lutheran Home For The Aged# 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>262</u>	Skilled (SNF)	<u>262</u>	<u>95,630</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>60</u>	Intermediate (ICF)	<u>60</u>	<u>21,900</u>	3
4		Intermediate/DD			4
5	<u>70</u>	Sheltered Care (SC)	<u>70</u>	<u>25,550</u>	5
6		ICF/DD 16 or Less			6
7	<u>392</u>	TOTALS	<u>392</u>	<u>143,080</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>614</u>	<u>1,306</u>	<u>9,241</u>	<u>11,161</u>	8
9	SNF/PED					9
10	ICF	<u>35,808</u>	<u>66,689</u>		<u>102,497</u>	10
11	ICF/DD					11
12	SC	<u>960</u>	<u>22,528</u>		<u>23,488</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>37,382</u>	<u>90,523</u>	<u>9,241</u>	<u>137,146</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 95.85%

D. How many bed-hold days during this year were paid by Public Aid?

330 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Meals on Wheels, Adult Day Care, Outpatient Therapy, Child Day Care

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 8/1/53

J. Was the facility purchased or leased after January 1, 1978?

YES ☐

Date \_\_\_\_\_

NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 252 and days of care provided 9,241Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/02 Fiscal Year: 6/30/02

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Lutheran Home For The Aged

# 0005090

Report Period Beginning:

07/01/02

Ending:

06/30/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	1,332,523	49,405		1,381,928		1,381,928	(386,707)	995,221			1
2	Food Purchase		1,806,159		1,806,159		1,806,159	(575,561)	1,230,598			2
3	Housekeeping	764,124	108,537	262,658	1,135,319		1,135,319	(321,254)	814,065			3
4	Laundry	130,558	61,554	31,151	223,263		223,263		223,263			4
5	Heat and Other Utilities			981,552	981,552		981,552	(352,811)	628,741			5
6	Maintenance	789,787	151,640	459,854	1,401,281		1,401,281	(193,054)	1,208,227			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	3,016,992	2,177,295	1,735,215	6,929,502		6,929,502	(1,829,387)	5,100,115			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			26,337	26,337		26,337		26,337			9
10	Nursing and Medical Records	9,107,154	658,646	9,424	9,775,224		9,775,224	(8,056)	9,767,168			10
10a	Therapy	263,292	35,059	24,101	322,452		322,452		322,452			10a
11	Activities	302,807	43,027	619	346,453		346,453	(19,081)	327,372			11
12	Social Services	212,008	3,043		215,051		215,051		215,051			12
13	Nurse Aide Training											13
14	Program Transportation			3,118	3,118		3,118		3,118			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	9,885,261	739,775	63,599	10,688,635		10,688,635	(27,137)	10,661,498			16
	<b>C. General Administration</b>											
17	Administrative	94,133		4,652,884	4,747,017		4,747,017	(4,239,225)	507,792			17
18	Directors Fees											18
19	Professional Services			231,671	231,671		231,671	29,331	261,002			19
20	Dues, Fees, Subscriptions & Promotions			30,267	30,267		30,267	52,367	82,634			20
21	Clerical & General Office Expenses	170,349	79,995	236,478	486,822		486,822	704,624	1,191,446			21
22	Employee Benefits & Payroll Taxes			1,061,495	1,061,495		1,061,495	1,929,486	2,990,981			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,797	11,797		11,797	58,109	69,906			24
25	Other Admin. Staff Transportation			231	231		231	7,996	8,227			25
26	Insurance-Prop.Liab.Malpractice			68,892	68,892		68,892	158,248	227,140			26
27	Other (specify):*							421,933	421,933			27
28	<b>TOTAL General Administration</b>	264,482	79,995	6,293,715	6,638,192		6,638,192	(877,131)	5,761,061			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	13,166,735	2,997,065	8,092,529	24,256,329		24,256,329	(2,733,655)	21,522,674			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Lutheran Home For The Aged

#0005090

Report Period Beginning:

07/01/02

Ending:

06/30/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			2,294,000	2,294,000		2,294,000	(689,459)	1,604,541			30
31	Amortization of Pre-Op. & Org.			32,279	32,279		32,279	(32,279)				31
32	Interest			1,414,175	1,414,175		1,414,175	(1,326,474)	87,701			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,335	2,335		2,335		2,335			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			3,742,789	3,742,789		3,742,789	(2,048,212)	1,694,577			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,300,886	1,039,456	2,340,342		2,340,342	(131,473)	2,208,869			39
40	Barber and Beauty Shops	114,043	17,568	655	132,266		132,266	(132,266)				40
41	Coffee and Gift Shops		44,817		44,817		44,817	(44,817)				41
42	Provider Participation Fee			176,295	176,295		176,295		176,295			42
43	Other (specify):*	299,739			299,739		299,739	(299,739)				43
44	<b>TOTAL Special Cost Centers</b>	413,782	1,363,271	1,216,406	2,993,459		2,993,459	(608,295)	2,385,164			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	13,580,517	4,360,336	13,051,724	30,992,577		30,992,577	(5,390,162)	25,602,415			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Lutheran Home For The Aged

# 0005090

Report Period Beginning: 07/01/02

Ending: 06/30/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care	\$	\$	1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(75,541)	2	4
5	Telephone, TV & Radio in Resident Rooms	(50,137)	21	5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation	(450,132)	30	9
10	Interest and Other Investment Income			10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax		02	13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt	(114,070)	21	24
25	Fund Raising, Advertising and Promotional			25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule	(4,228,765)		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,918,645)	\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
33	Amortization of Organization & Pre-Operating Expense		33
34	Adjustments for Related Organization Costs (Schedule VII)	(471,517)	34
35	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (471,517)	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (5,390,162)	37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

## Lutheran Home For The Aged

Report Period Beginning: 07/01/02  
 Ending: 06/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1	Misc. Income	5	11
2	Misc. Op - Volunteers	(2,656)	21
3	Misc. Op - Arts & Crafts	(3,037)	11
4	Printing Income - Internal	(1,305)	21
5	Concert Series	(18,854)	11
6	Application Fees	(31,772)	21
7	Hearing Aid Income	(56)	21
8	E.V. - Apt Cleaning	(81,158)	2
9	E.V. - Medical Fees	(5,888)	10
10	E.V. - Housekeeping / POM	(173,771)	6
11	E.V. - Security	(26,727)	6
12	E.V. - Housekeeping	(198,288)	2
13	Cable TV	(55,568)	5
14	Amortization	(12,279)	31
15	Beauty Shop	(142,266)	40
16	Vacancy Short	(64,817)	41
17	Hearthstone Food Service - Salaries	(299,739)	43
18	Seminary - Out of State	(2,261)	24
19	IRA Dues	(18,758)	29
20	Non-Care Utilities	(297,243)	5
21	Non-Care Housekeeping	(49,786)	2
22	Hearthstone: Adult Day Care - Dietary	(286,707)	1
23	Hearthstone: Adult Day Care - Food	(466,983)	2
24	Non-Care Interest	(565,984)	32
25	Investment Income	(778,499)	32
26	Capitalized R&M	(68,588)	5
27	Non-Care Depreciation	(234,557)	30
28	Professional Fees - ARK Development	(91,264)	19
29	Misc. Income - Supplies	(58)	19
30	Misc. Income - Various	(243)	21
31	Misc. Income - Interest Income	(4)	32
32	Misc. Income - Sale of Auto	(4,779)	30
33	Misc. Income - Property Damage Payment	(4,861)	6
34	Food Discounts	(23,778)	2
35	Pharmacy Discounts	(121,473)	39
36	Other Discounts	(1,447)	21
37	Satisfaction Survey - Marketing	(2,978)	19
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100			
101	Total	(4,228,765)	101

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lutheran Home For The Aged# 0005090

Report Period Beginning:

07/01/02

Ending:

06/30/03**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(386,707)											(386,707)	1
2	Food Purchase	(566,302)		(9,259)									(575,561)	2
3	Housekeeping	(321,254)											(321,254)	3
4	Laundry													4
5	Heat and Other Utilities	(352,811)											(352,811)	5
6	Maintenance	(273,067)		80,013									(193,054)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(1,900,141)</b>		<b>70,754</b>									<b>(1,829,387)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(8,056)											(8,056)	10
10a	Therapy													10a
11	Activities	(19,081)											(19,081)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(27,137)</b>											<b>(27,137)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(4,239,225)									(4,239,225)	17
18	Directors Fees													18
19	Professional Services	(94,236)		123,567									29,331	19
20	Fees, Subscriptions & Promotions	(18,750)		71,117									52,367	20
21	Clerical & General Office Expenses	(201,680)		906,304									704,624	21
22	Employee Benefits & Payroll Taxes			1,929,486									1,929,486	22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,261)		60,370									58,109	24
25	Other Admin. Staff Transportation			7,996									7,996	25
26	Insurance-Prop.Liab.Malpractice			158,248									158,248	26
27	Other (specify):*			421,933									421,933	27
28	<b>TOTAL General Administration</b>	<b>(316,927)</b>		<b>(560,204)</b>									<b>(877,131)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(2,244,205)</b>		<b>(489,450)</b>									<b>(2,733,655)</b>	<b>29</b>





VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		Wittenberg Lutheran Village, Inc.	Crown Point, IN	See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Administrative Allocation	\$ 4,652,884	Lutheran Home and Services for the Aged	100.00%	\$	\$ (4,652,884)
16	V	2 Food Purchase		Lutheran Home and Services for the Aged	100.00%	(9,259)	(9,259)
17	V	6 Repairs & Maintenance		Lutheran Home and Services for the Aged	100.00%	80,013	80,013
18	V	17 Administrative Allocation		Lutheran Home and Services for the Aged	100.00%	413,659	413,659
19	V	19 Professional Fees		Lutheran Home and Services for the Aged	100.00%	123,567	123,567
20	V	20 Dues & Subscriptions		Lutheran Home and Services for the Aged	100.00%	71,117	71,117
21	V	21 Clerical & General Office		Lutheran Home and Services for the Aged	100.00%	906,304	906,304
22	V	22 Employee Benefits		Lutheran Home and Services for the Aged	100.00%	1,929,486	1,929,486
23	V	24 Travel & Seminar		Lutheran Home and Services for the Aged	100.00%	60,370	60,370
24	V	25 Other Admin. Staff Transportation		Lutheran Home and Services for the Aged	100.00%	7,996	7,996
25	V	26 Liability Insurance		Lutheran Home and Services for the Aged	100.00%	158,248	158,248
26	V	27 Other - Employee Benefits		Lutheran Home and Services for the Aged	100.00%	421,933	421,933
27	V	32 Interest Expense		Lutheran Home and Services for the Aged	100.00%	17,933	17,933
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 4,652,884			\$ 4,181,367	\$ * (471,517)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Roger Paulsberg	Chairman	Administrative	0	see attached	34	85.00	alloc salary	\$ 122,833	17-7	1
2	Penny Paulsberg	Spouse	Interior Design	0				fees	59,439	19-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 182,272		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Lutherna Home & Services for the Aged, Inc.  
 Street Address 800 West Oakton  
 City / State / Zip Code Arlington Hts, IL 60004  
 Phone Number ( 847) 253-3710  
 Fax Number ( 847) 253-1427

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchase	Direct Cost	(11,467)	3	\$ (11,467)	\$ (9,259)	\$ (9,259)	1
2	6	Repairs & Maintenance	Direct Cost	129,902	3	129,902	80,013	80,013	2
3	10	Nursing & Medical Records	Direct Cost	31,160	3	31,160			3
4	17	Administrative	Direct Cost	512,272	3	512,272	413,659	413,659	4
5	19	Professional Fees	Direct Cost	162,067	3	162,067	123,567	123,567	5
6	20	Dues & Subscriptions	Direct Cost	387,851	3	387,851	71,117	71,117	6
7	21	Clerical & General Office	Direct Cost	1,205,711	3	1,205,711	915,237	906,304	7
8	22	Employee Benefits	Direct Cost	1,929,486	3	1,929,486	1,929,486	1,929,486	8
9	24	Travel & Seminar	Direct Cost	111,091	3	111,091	60,370	60,370	9
10	25	Other Admin. Staff Trans.	Direct Cost	10,366	3	10,366	7,996	7,996	10
11	26	Liability Insurance	Direct Cost	195,972	3	195,972	158,248	158,248	11
12	27	Other - Employee Benefits	Direct Cost	824,262	3	824,262	421,933	421,933	12
13	32	Interest Expense	Direct Cost	22,208	3	22,208	17,933	17,933	13
14	43	Hearthstone / Other	Direct Cost	427,904	3	427,904	427,904		14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 5,938,785	\$ 1,855,413	\$ 4,181,367	25

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25



Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Lutheran Home For The Aged # 0005090 Report Period Beginning: 07/01/02 Ending: 06/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$										
2																			
3																			
4																			
5	See Supplemental Schedule																	17,929	5
	Working Capital																		
6	Interest on Resident Assets		X															17,945	6
7																			7
8	See Supplemental Schedule																		8
9	TOTAL Facility Related						\$		\$								\$	35,874	9
	B. Non-Facility Related*																		
10	Revenue Bonds		X	Residential Unit Construction				24,285,000	28,077,814	8/15/26	various							1,396,230	10
11	Non-Care Interest																	(565,904)	11
12	Investment Income																	(778,499)	12
13	See Supplemental Schedule																		13
14	TOTAL Non-Facility Related						\$	24,285,000	\$	28,077,814							\$	51,827	14
15	TOTALS (line 9+line14)						\$	24,285,000	\$	28,077,814							\$	87,701	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Allocated from LHSA						\$	\$			\$	17,933	1
2	Interest Income											-4	2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term											17,929	7
	Working Capital												
8							\$	\$			\$		8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lutheran Home For The Aged COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0005090

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		<b>TOTALS</b>	\$ <u></u>	\$ <u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lutheran Home For The Aged COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0005090

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE (     ) \_\_\_\_\_ FAX #: (     ) \_\_\_\_\_

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>          </u>	\$ <u>          </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lutheran Home For The Aged# 0005090

Report Period Beginning:

07/01/02

Ending:

06/30/03**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 315,041 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Lutheran Home & Services for the Aged, Inc. - Parent CorporationLutheran Community Services for the Aged, Inc. - Family Support ServicesLutheran Foundation for the Aged - Fund Raising ActivitiesHearthstone Supportive Apartments - 100 beds, 89,048 square feetChild Day Care - 6448 square feetAdult Day Care - 5088 square feetF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	871,200	1922	\$ 20,000	1
2	Cemetery	43,560	1896	225	2
3	TOTALS	914,760		\$ 20,225	3

**XL OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	125		1953	1953	\$ 1,242,090	\$ 15,969	50	\$ 15,969	\$	\$ 1,242,090	4
5			1962	1962	82,773	2,365	50	2,365		70,827	5
6	102		1966	1966	1,196,550	34,187	50	34,187		916,235	6
7	126		1973	1973	2,431,047	69,458	50	69,458		1,521,139	7
8	126		1978	1978	3,398,949	97,113	50	97,113		1,854,972	8
9	Improvement Type**										
9	RESIDENT GIFT SHOP			1976	10,801		50	309	309	6,327	9
10	LAND IMPROVEMENT			1980	128,110		50	3,660	3,660	64,786	10
11	VARIOUS			1981	1,686,911		50	48,198	48,198	819,357	11
12	VARIOUS			1982	881,456		50	25,184	(25,184)	410,504	12
13	REMODEL			1983	733,983		50	20,971	20,971	327,148	13
14	WINDOW REPLACEMENT			1984	650,719		50	18,592	18,592	277,020	14
15	REMODEL			1985	335,901		50	9,597	9,597	136,279	15
16	REMODEL			1986	31,815		50	909	909	12,271	16
17	REMODEL COMMON AREA			1987	36,747		50	1,050	1,050	13,439	17
18	REMODEL COMMON AREA			1988	125,105		50	3,574	3,574	43,249	18
19	REMODEL COMMON AREA			1989	5,271		50	151	151	1,717	19
20	REMODEL COMMON AREA			1990	9,600		50	274	274	2,660	20
21	REMODEL COMMON AREA			1991	65,975		50	1,885	1,885	18,851	21
22	REMODEL COMMON AREA			1992	254,620		50	7,275	7,275	66,934	22
23	REMODEL COMMON AREA			1993	60,706		50	1,734	1,734	14,916	23
24	REMODEL COMMON AREA			1994	164,661		50	4,705	4,705	37,168	24
25	REMODEL COMMON AREA			1995	40,474		50	1,156	1,156	8,325	25
26	VARIOUS			1996	40,722		50	1,165	1,165	7,332	26
27	VARIOUS			1997	20,182		50	576	576	3,326	27
28	VARIOUS			1998	7,103,694		various	210,704	210,704	987,266	28
29	VARIOUS			1999	4,703,451		various	138,801	138,801	570,555	29
30	VARIOUS			2000	732,300		various	30,679	30,679	91,130	30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	CABLING-ACCTG(9960)	2001	7,620		15	\$ 508	\$ 508	\$ 1,270		37
38	CABLING	2001	887		15	59	59	143		38
39	CABLING-ACCTG(8815)	2001	6,744		15	450	450	1,087		39
40	CABLING	2001	770		15	51	51	123		40
41	CABLING	2001	2,391		15	159	159	384		41
42	CABLING	2001	660		15	44	44	106		42
43	CABLING	2001	2,397		15	160	160	387		43
44	CABLING	2001	1,950		35	56	56	121		44
45	CABLING	2001	613		35	18	18	37		45
46	CABLING	2001	279		35	8	8	17		46
47	CABLING	2001	448		35	13	13	27		47
48	CABLING	2001	180		35	5	5	10		48
49	ARCHITECT FEES	2001	46,189		35	1,320	1,320	3,190		49
50	ARCHITECT FEES	2001	5,867		35	168	168	406		50
51	PANTRY WORK	2001	79,365		35	2,268	2,268	5,481		51
52	J WING IN SERVICE (2570,048)	2001	2,005,151		35	57,290	57,290	145,176		52
53	J WING IN SERVICE (133,475)	2001	104,137		35	2,975	2,975	7,539		53
54	BUILDING CIP IN SERVICE (2771,178)	2001	2,113,855		35	60,396	60,396	153,782		54
55	CREDIT FROM BOND PERMIT FEE	2001	(1,255)		35	(36)	(36)	(87)		55
56	BLINDS	2001	798		20	40	40	97		56
57	ELECTRICAL WIRING-ACCTG(2274)	2001	1,740		20	87	87	210		57
58	ELECTRICAL-ACCTG (2678)	2001	2,049		20	102	102	238		58
59	SECURITY CAMERA(1287)	2001	985		20	49	49	119		59
60	SINKS	2001	7,373		20	369	369	830		60
61	HVAC COMPRESSOR	2001	4,397		20	220	220	495		61
62	ROOF REPAIR	2001	2,373		20	119	119	278		62
63	BOILER REPAIRS(5423)	2001	4,149		20	207	207	466		63
64	BUTTERFLY VALVE(1199)	2001	917		20	46	46	111		64
65										65
66										66
67										67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)									68
69	Financial Statement Depreciation			1,294,100			(1,294,100)			69
70	TOTAL (lines 4 thru 69)		\$ 30,577,642	\$ 1,513,192		\$ 877,392	\$ (686,168)	\$ 9,847,866		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 30,577,642	\$ 1,513,192		\$ 877,392	\$ (635,800)	\$ 9,847,866	1
2	ELECTRICAL	2001	1,395		20	70	70	152	2
3	CIRCUIT BREAKER (2554)	2001	1,948		35	56	56	112	3
4	WINDOWS	2001	10,885		35	311	311	596	4
5	WINDOWS	2001	20,045		35	573	573	1,174	5
6	SINKS, COUNTERTOPS, FAUETS	2001	12,280		35	351	351	526	6
7	CHAIN LINK FENCE (2980)	2002	2,274		35	65	65	97	7
8	CEILING TILES	2002	3,362		35	96	96	136	8
9	CABLING (688)	2002	525		35	15	15	21	9
10	CABLING (608)	2002	464		35	13	13	19	10
11	DOORS	2002	6,950		35	199	199	282	11
12	VINYL TILE	2002	1,015		35	29	29	39	12
13	SINKS, COUNTERTOPS, FAUETS	2001	14,596		35	417	417	556	13
14	SINKS, COUNTERTOPS, FAUETS	2002	19,928		35	569	569	759	14
15	SEALANTS	2002	7,450		35	213	213	284	15
16	DECORATING	2002	750		35	21	21	26	16
17	CABLING (2091)	2002	1,595		35	46	46	57	17
18	SINKS, COUNTERTOPS, FAUETS	2002	23,452		35	670	670	838	18
19	PAINTING & DECORATING	2002	9,550		35	273	273	318	19
20	PAINTING & DECORATING (5325)	2002	4,062		35	116	116	135	20
21	WALL REPAIR (7088)	2002	5,407		35	154	154	193	21
22	SIGNS	2002	1,940		35	55	55	64	22
23	DOOR SYSTEM (3300)	2002	2,517		35	72	72	96	23
24	COMPUTER CABLING (2305)	2002	1,758		35	50	50	58	24
25	COMPUTER CABLING (1456)	2002	1,111		35	32	32	35	25
26	FLOOR TILES(2150)	2002	1,640		35	47	47	55	26
27	ROOF TOP UNIT (137,740)	2002	105,068		35	3,002	3,002	3,252	27
28	AIR CONDITIONING UNITS (7600)	2001	5,798		20	290	290	459	28
29	COMPRESSOR (27613)	2001	21,063		20	1,053	1,053	2,018	29
30	CARPET (16608)	2001	12,669		20	633	633	1,003	30
31	BARRIER GATE (4728)	2001	3,607		20	180	180	285	31
32	DRAPERIES	2001	2,940		20	147	147	221	32
33	DRAPERIES	2001	966		20	48	48	72	33
34	TOTAL (lines 1 thru 33)		\$ 30,886,652	\$ 1,513,192		\$ 887,258	\$ (625,934)	\$ 9,861,804	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 31,100,967	\$ 1,513,192		\$ 897,975	\$ (615,217)	\$ 9,875,910	1
2	EXIT SIGN	2002	683		20	34	34	51	2
3	LANDSCAPING (1724)	2002	1,417		20	71	71	85	3
4	GAZEBO (3435)	2001	2,824		20	141	141	282	4
5	PAINTING / DECORATING	2002	4,675		20	234	234	331	5
6	PAINTING / DECORATING	2002	4,464		20	223	223	316	6
7	PUMP (2547)	2002	2,094		20	105	105	122	7
8	H WING RENOVATION (2,009,543)	2001	1,651,844		20	82,592	82,592	247,776	8
9	ENCLOSURE - ACROSS FROM FOLDING ROOM (3150)	2002	2,402		20	120	120	180	9
10	CARPETING WITH VINYL BASE	2002	17,263		20	863	863	1,151	10
11	SINKS, COUNTERS, WARDROBES	2002	23,402		20	1,170	1,170	1,560	11
12	ORTRONICS MODULE PATCH PANEL (153)	2002	116		20	6	6	8	12
13	BLOWER, HEATER, PENTHOUSE (2355)	2001	1,796		20	90	90	150	13
14	SHUT OFF VALVES & PIPE WRAP (3802)	2001	2,900		20	145	145	230	14
15	PARTIAL BILLING - EML (20,980)	2002	16,004		20	800	800	1,067	15
16	SPEAKERS FROM OVERHEAD PAGE SYSTEM (4087)	2002	3,118		20	156	156	208	16
17	SPEAKERS FROM OVERHEAD PAGE SYSTEM (1183)	2002	902		20	45	45	60	17
18	SECURITY SYSTEM (1125)	2002	858		20	43	43	57	18
19	SECURITY SYSTEM (907)	2002	692		20	35	35	47	19
20	H WING RENOVATION - ACCTG & COMPUTER (165,000)	2002	125,862		20	6,293	6,293	18,879	20
21	5 A/C UNITS NURSING PAVILION	2002	283,900		20	14,195	14,195	42,585	21
22	MASONRY WORK G-WING	2001	20,760		20	1,038	1,038	1,557	22
23	MASONRY WORK E-WING	2001	17,695		20	885	885	1,327	23
24	MASONRY WORK E-WING	2001	9,840		20	492	492	738	24
25	MASONRY WORK H-WING (15,930)	2001	13,094		20	655	655	982	25
26	MASONRY WORK G-WING	2001	26,965		20	1,348	1,348	2,022	26
27	PHONE SYSTEM (159)	** 2002	121		20	6	6	6	27
28	PHONE SYSTEM	** 2002	671		20	34	34	34	28
29	ROOF TOP UNITS (4640)	** 2002	3,539		20	177	177	177	29
30	GAS PIPING (119,900)	** 2002	91,460		20	4,573	4,573	4,573	30
31	PHONE SYSTEM (1100)	** 2002	839		20	42	42	42	31
32	WIRING - ALARM SYSTEM	** 2002	15,130		20	757	757	757	32
33	PHONE SYSTEM (1647)	** 2002	502		20	25	25	25	33
34	TOTAL (lines 1 thru 33)		\$ 33,448,799	\$ 1,513,192		\$ 1,015,367	\$ (497,825)	\$ 10,203,295	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 33,448,799	\$ 1,513,192		\$ 1,015,367	\$ (497,825)	\$ 10,203,295	1
2	PHONE SYSTEM (326)	2003	249		20	12	12	12	2
3	KITCHEN DESIGN (7200)	2003	5,492		20	275	275	275	3
4	KITCHEN DESIGN (7875)	2003	6,007		20	300	300	300	4
5	SIGNAGE	2003	200		20	10	10	10	5
6	LOCKS	2003	5,056		20	253	253	253	6
7	SIGNAGE	2003	86		20	4	4	4	7
8	KITCHEN DESIGN (512)	2003	390		20	20	20	20	8
9	ELEVATOR REPAIR	2003	3,064		20	153	153	153	9
10	SIGNAGE	2003	4,723		20	236	236	236	10
11	PLUMBING (270)	2003	206		20	10	10	10	11
12	PHONE SYSTEM	2003	120		20	6	6	6	12
13	PHONE SYSTEM	2003	770		20	39	39	39	13
14	CEILING TILE	2003	2,688		20	134	134	134	14
15	PHONE SYSTEM	2003	100		20	5	5	5	15
16	ELECTRICAL LINES (4556)	2003	3,475		20	174	174	174	16
17	NURSE CALL SYSTEM	2003	23,500		20	1,175	1,175	1,175	17
18	NURSE CALL SYSTEM	2003	62,243		20	3,112	3,112	3,112	18
19	PHONE SYSTEM (1691)	2003	856		20	43	43	43	19
20	ROOF TOP UNITS (5000)	*	3,814		20	191	191	191	20
21	NURSE CALL SYSTEM	2003	30,000		20	1,500	1,500	1,500	21
22	PHONE SYSTEM (442)	2003	337		20	17	17	17	22
23	CEILING TILE (9374)	2003	7,150		20	358	358	358	23
24	ROOF TOP UNITS (20000)	2003	15,256		20	763	763	763	24
25	ROOF TOP UNITS (6260)	2003	4,775		20	239	239	239	25
26	SECURITY SYSTEM (9975)	*	7,609		20	380	380	380	26
27	WATER HEATER (38000)	*	28,986		20	1,449	1,449	1,449	27
28	CARPETING	2003	2,950		20	148	148	148	28
29	CARPETING	2003	2,880		20	144	144	144	29
30	CARPETING	2003	3,625		20	181	181	181	30
31	WATER HEATER (29000)	*	22,121		20	1,106	1,106	1,106	31
32	WATER HEATER (41000)	*	31,275		20	1,564	1,564	1,564	32
33	PUMP (6800)	2003	5,187		20	259	259	259	33
34	TOTAL (lines 1 thru 33)		\$ 33,733,989	\$ 1,513,192		\$ 1,029,625	\$ (483,567)	\$ 10,217,555	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 33,733,989	\$ 1,513,192		\$ 1,029,625	\$ (483,567)	\$ 10,217,555	1
2	COMPRESSOR (11795)	2003	8,997		20	450	450	450	2
3	WATER HEATER (10000)	*	7,628		20	381	381	381	3
4	PLUMBING (1375)	*	1,049		20	52	52	52	4
5	PLUMBING (3790)	*	2,891		20	145	145	145	5
6	SEWER LINES (11730)	*	8,948		20	447	447	447	6
7	STRUCTURAL REPAIRS (42167)	*	32,165		20	1,608	1,608	1,608	7
8	PAVEMENT REPAIRS (6931)	*	5,287		20	264	264	264	8
9	SURVEY (1182)	*	902		20	45	45	45	9
10	ENGINEERING (5500)	*	4,195		20	210	210	210	10
11	SEWER LINES (3225)	*	2,460		20	123	123	123	11
12	ENGINEERING (4903)	*	3,740		20	187	187	187	12
13	PHONE SYSTEM (565366)		431,261		20	21,563	21,563	21,563	13
14	PHONE SYSTEM (52202)		39,820		20	1,991	1,991	1,991	14
15	LOCKS (509)	*	389		20	19	19	19	15
16	DOOR CLOSURES (1358)	*	1,036		20	52	52	52	16
17	PUMP, CIRCULATOR (708)	*	540		20	27	27	27	17
18	DOOR CLOSURES (992)	*	757		20	38	38	38	18
19	LANDSCAPING (3088)	*	2,355		20	118	118	118	19
20	LANDSCAPING (1236)		943		20	47	47	47	20
21	LANDSCAPING (970)	*	740		20	37	37	37	21
22	CANOPY (950)	*	725		20	36	36	36	22
23	COMPRESSION COUPLERS (2000)	*	1,526		20	76	76	76	23
24	ELECTRICAL CIRCUITS (5120)	*	3,906		20	195	195	195	24
25	CARPET REPAIR (1656)	*	1,263		20	63	63	63	25
26	ENTRANCE DOOR REPAIR (849)	*	648		20	32	32	32	26
27	SPRINKLER HEADS (681)		519		20	26	26	26	27
28	SECURITY SYSTEM (1770)	*	1,350		20	68	68	68	28
29	HOT WATER BOILERS (2271)	*	1,732		20	87	87	87	29
30	PLUMBING, PIPING (637)	*	486		20	24	24	24	30
31	ROOF EXHAUST FAN (650)		496		20	25	25	25	31
32	BOILER REPAIR (2130)		1,625		20	81	81	81	32
33	PIPE REPLACEMENT (2350)		1,793		20	90	90	90	33
34	TOTAL (lines 1 thru 33)		\$ 34,306,161	\$ 1,513,192		\$ 1,058,232	\$ (454,960)	\$ 10,246,162	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**\*\*Improvement type must be detailed in order for the cost report to be considered complete.**

## XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 34,333,373	\$ 1,513,192		\$ 1,059,593	\$ (453,599)	\$ 10,247,524	1
2									2
3									3
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10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 34,333,373	\$ 1,513,192		\$ 1,059,593	\$ (453,599)	\$ 10,247,524	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 34,333,373	\$ 1,513,192		\$ 1,059,593	\$ (453,599)	\$ 10,247,524	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 34,333,373	\$ 1,513,192		\$ 1,059,593	\$ (453,599)	\$ 10,247,524	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 34,333,373	\$ 1,513,192		\$ 1,059,593	\$ (453,599)	\$ 10,247,524	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 34,333,373	\$ 1,513,192		\$ 1,059,593	\$ (453,599)	\$ 10,247,524	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 34,333,373	\$ 1,513,192		\$ 1,059,593	\$ (453,599)	\$ 10,247,524	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 34,333,373	\$ 1,513,192		\$ 1,059,593	\$ (453,599)	\$ 10,247,524	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
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26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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62									62
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,673,197	\$ 524,050	\$ 527,517	\$ 3,467	10	\$ 5,997,561	71
72	Current Year Purchases	331,528				10		72
73	Fully Depreciated Assets	1,716,400				10	1,716,400	73
74								74
75	TOTALS	\$ 7,721,125	\$ 524,050	\$ 527,517	\$ 3,467		\$ 7,713,961	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Ford Club Wagon	1997	\$ 100,711	\$	\$ 12,733		5	\$ 100,711	76
77	Patient Care	2002 Goshen Bus	2001	50,932	12,733	12,733		4	21,222	77
78	Housekeeping	2000 Ford Truck Explorer	2001	18,793	4,698	4,698	(0)	4	6,264	78
79										79
80	TOTALS			\$ 170,436	\$ 17,431	\$ 17,431	\$ (0)		\$ 128,197	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 42,245,159	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,054,673	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,604,541	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (450,132)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 18,089,682	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	see attached schedule	\$ 13,259,060	\$ 234,557	\$ 1,303,033	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 13,259,060	\$ 234,557	\$ 1,303,033	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,335 Description: Medical Equipment

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 227,828	\$		\$ 227,828	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			70,201			70,201	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			695,242			695,242	4
5	Physician Care	39 - 03	visits			8,566			8,566	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				919,073		919,073	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					37,619	381,813		419,432	13
14	TOTAL			\$		\$ 1,039,456	\$ 1,300,886		\$ 2,340,342	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,745,568	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,054,895		3
4	Supply Inventory (priced at )	91,839		4
5	Short-Term Investments	(269,276)		5
6	Prepaid Insurance	24,629		6
7	Other Prepaid Expenses	138,784		7
8	Accounts Receivable (owners or related parties)	900,000		8
9	Other(specify): <a href="#">See Supplemental Schedule</a>	310,775		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,997,214	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	4,443,487		12
13	Land	20,225		13
14	Buildings, at Historical Cost	45,593,126		14
15	Leasehold Improvements, at Historical Cost	430,185		15
16	Equipment, at Historical Cost	10,294,150		16
17	Accumulated Depreciation (book methods)	(19,651,844)		17
18	Deferred Charges	1,406,567		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	671,656		22
23	Other(specify): <a href="#">See Supplemental Schedule</a>	8,828		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 43,216,380	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 49,213,594	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 886,956	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,553		28
29	Short-Term Notes Payable	385,000		29
30	Accrued Salaries Payable	1,250,096		30
31	Accrued Taxes Payable (excluding real estate taxes)	76,758		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	436,987		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Supplemental Schedule</a>	8,999,048		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 12,104,398	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	27,692,814		41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Supplemental Schedule</a>	1,470,213		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 29,163,027	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 41,267,425	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 7,946,169	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 49,213,594	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>9,554,063</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>9,554,063</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,607,894)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,607,894)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>7,946,169</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Lutheran Home For The Aged

# 0005090

Report Period Beginning: 07/01/02

Ending:

06/30/03

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 27,315,618	1
2	Discounts and Allowances for all Levels	(6,198,330)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 21,117,288	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,054,425	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,054,425	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	185,885	13
14	Non-Patient Meals	75,541	14
15	Telephone, Television and Radio	50,137	15
16	Rental of Facility Space	1,045,133	16
17	Sale of Drugs	1,302,114	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,424	19
20	Radiology and X-Ray	5,543	20
21	Other Medical Services	5	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 2,703,782	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	1,651,710	24
25	Interest and Other Investment Income***	237,747	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,889,457	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	619,731	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 619,731	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 29,384,683	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	6,929,502	31
32	Health Care	10,688,635	32
33	General Administration	6,638,192	33
	<b>B. Capital Expense</b>		
34	Ownership	3,742,789	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	2,817,164	35
36	Provider Participation Fee	176,295	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 30,992,577	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,607,894)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,607,894)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



## STATE OF ILLINOIS

Page 20

Facility Name & ID Number Lutheran Home For The Aged# 0005090Report Period Beginning: 07/01/02Ending: 06/30/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,755	1,815	\$ 75,983	\$ 41.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	98,443	131,891	2,916,099	22.11	3
4	Licensed Practical Nurses	24,717	27,552	578,602	21.00	4
5	Nurse Aides & Orderlies	392,472	437,497	5,468,712	12.50	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	14,081	15,607	263,292	16.87	8
9	Activity Director					9
10	Activity Assistants	20,425	22,699	302,807	13.34	10
11	Social Service Workers	10,212	11,424	212,008	18.56	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	111,974	125,473	1,332,523	10.62	15
16	Dishwashers					16
17	Maintenance Workers	45,644	50,369	789,787	15.68	17
18	Housekeepers	78,019	86,050	764,124	8.88	18
19	Laundry	12,837	14,331	130,558	9.11	19
20	Administrator	1,748	1,950	94,133	48.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,793	7,519	170,349	22.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,678	4,094	67,758	16.55	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	30,090	33,445	413,782	12.37	33
34	TOTAL (lines 1 - 33)	852,888	971,716	\$ 13,580,517 *	\$ 13.98	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	26,337	09-03	36
37	Medical Records Consultant	monthly	4,331	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	5,093	10-03	39
40	Physical Therapy Consultant	438	24,101	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	11	619	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	450	\$ 60,481		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number **Lutheran Home For The Aged**# **0005090**Report Period Beginning: **07/01/02**Ending: **06/30/03****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description			Description		
Marie Payes	Admin (thur 2/18/03)	0	\$ 56,302	Workers' Compensation Insurance	\$		IDPH License Fee	\$	
Jim Holbrook	Admin (eff. 2/18/03)	0	37,831	Unemployment Compensation Insurance			Advertising: Employee Recruitment		
				FICA Taxes		1,034,081	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance			Subscriptions & Publications	7,994	
				Employee Meals			Organization Dues	3,523	
				Illinois Municipal Retirement Fund (IMRF)*			Allocated from LHSA	71,117	
				Volunteer Recognition		14,636			
				Other Employee Benefit		12,778			
				Allocated from LHSA		1,929,486			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 94,133	TOTAL (agree to Schedule V, line 22, col.8)		\$ 2,990,981	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 82,634
B. Administrative - Other							Less: Public Relations Expense ( )		
Description			Amount				Non-allowable advertising ( )		
Allocated cost - Lutheran Home & Services for the Aged, Inc.			\$ 4,652,884				Yellow page advertising ( )		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 4,652,884	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services			Amount	Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type								
Michael Best & Friedrich	Legal		\$ 47,471				Out-of-State Travel	\$	
KPMG	Accounting		22,000						
Ark Development	adjusted out on page 5		91,261				In-State Travel		
Achieve Accreditation	Computer		5,717						
Carl Johnson	Administrative Consult.		2,808						
Penny Paulsberg	Decorating Service		59,439				Seminar Expense	9,537	
LSN	Satisfaction Survey (adj p. 5)		2,975				Allocation from LHSA	60,370	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 231,671	TOTAL		\$	Entertainment Expense ( )		
							(agree to Sch. V, line 24, col. 8)	\$ 69,907	

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number Lutheran Home For The Aged

STATE OF ILLINOIS

# 0005090

Report Period Beginning:

07/01/02

Ending:

Page 23

06/30/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Dues paid by related party
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 296,595 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 176,295  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 75,541
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln. 14  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.